MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 95-2

Reg. Dist. No. 76

CERTIFICATE OF DEATH

01685

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Eastview, Md.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 62

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Carroll

(c) City or town Rural, Eastview, Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. R.D. #6 Westminster,
(If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Samuel G. Arnold

3 (b) If veteran, name war No.

3 (c) Social Security No. No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of ~~husband or~~ wife Caroline Arnold

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 9, 1849

8. AGE: Years 90 Months 7 Days 13 If less than one day ____ hr. ____ min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER
12. Name James Arnold
13. Birthplace Maryland.

MOTHER
14. Maiden Name Barbara Criswell
15. Birthplace Maryland.

16 (a) Informant Mr. Samuel Arnold.
(b) Address R.D. Westminster, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24, 1940 (month) (day) (year)
(c) Cemetery or crematory Deer Park.
Location Smallwood, Md.

18 (a) Funeral director C. M. Waltz
(b) Address Winfield - Md.

19 (a) 2/23/40 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. Date of death Feb. 22, 1940, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19th 1940, to Feb. 22 1940, and that I last saw him alive on Feb. 19th 1940.

Immediate cause of death Acute Dilatation of heart

Due to Senility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration: few minutes; 20 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. T. Billingslea M. D. or other

Address Westminster, Md. Date signed 2/22/40

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

01686

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Gamber, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 40 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Gamber Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R. D. Finksburg, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No.

3. (a) FULL NAME: William T. Barnes

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife: Mary A. Barnes

6(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Oct. 15, 1862

8. AGE:

Years	Months	Days	If less than one day
77	3	27	____ hrs. ____ min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Chair Maker.

11. Industry or business

FATHER
12. Name: William H. Barnes
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Cordelia Becraft
15. Birthplace: Maryland

16. Informant: Mrs. Mary A. Barnes
Address: R. D. Finksburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-15-'40 (month) (day) (year)

Cemetery or crematory: Mt. Pleasant

Location: Gamber, Maryland.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. 2/13/40 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12 1940, at 5 A.M. Prior to

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw him alive on ____ 19__.

Immediate cause of death	DURATION
Cerebral Hemorrhage	7
Due to	
Arterio-Sclerosis	—
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work? ____

23. SIGNATURE: Jas. T. Hook Deputy Medical Examiner
M. D. or other

Address: New Windsor Md. Date signed Feb. 12-40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01687

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 5 years 8 mo.

Stay in this community (yrs., or mos., or days): 6 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Bel Air Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Josephine Barranco

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): November — 1908

8. AGE:

Years	Months	Days	If less than one day
31	3		hrs. min.

9. Birthplace: Mississippi
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Vincent Barranco
13. Birthplace: Italy

MOTHER
14. Maiden name: Josephine Sarsone
15. Birthplace: Mississippi

16. Informant: Hospital Records
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 2-19-40 (month) (day) (year)

Cemetery or crematory: St. Ignatius Cem.

Location

18. Funeral director: Dean & Frates

Address: Bel Air Md.

19. 2-15-40 (Date rec'd by registrar) 19 Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1940, at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 16 1939, to February 14 1940, and that I last saw her alive on February 14 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1939
Due to	
Due to	
Other conditions: Epilepsy	18 years

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D.
M. D. or other

Address Sykesville, Md. Date signed Feb. 14-1940

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01688

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 13 yr. 6 mos. 9 days

Stay in this community (yrs., or mos., or days): same

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Street Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Joseph Ingle Basham

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B (b) Name of husband or wife: Unknown

6(c) If alive, give age: Unk. years

7. Birth date of deceased (mo., day, yr.): September 4, 1859

8. AGE: Years	Months	Days	If less than one day
80	5	23	____ hrs. ____ min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Benjamin Basham
13. Birthplace: Virginia

MOTHER
14. Maiden name: Millie Ridinger
15. Birthplace: Virginia

16. Informant: Springfield Hospital Record
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-1-40 (month) (day) (year)

Cemetery or crematory: Darlington Cemetery

Location: Darlington Md.

18. Funeral director: Herbert S. Bailey

Address: Darlington Md.

19. 2-28-40 (Date rec'd by registrar) 19__ Harry Wiley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27, 1940, at 8:55 p.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 1936, to Feb. 27, 1940, and that I last saw him alive on Feb. 27, 1940.

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to Arteriosclerosis	
Due to	
Other conditions: Psychosis with Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	13 yrs.

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M. D.
M. D. or other

Address: Sykesville, Md. Date signed 2-27-40.

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01689

131-P

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or Insf. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 13 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John M. Baumgardner

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	married

6 (b) Name of husband or wife Grace R. Martin Baumgardner 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26, 1866

8. AGE:

Years	Months	Days	If less than one day
73	2.	16	hrs. min.

9. Birthplace Frederick Co. Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Moses Baumgardner
13. Birthplace Md

MOTHER
14. Maiden name Anna Stambaugh
15. Birthplace Md

16. Informant Mrs Grace Baumgardner
Address Taneytown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 13-'40. (month) (day) (year)
Cemetery or crematory Cemetery
Location Keysville, Md.

18. Funeral director C. A. Snader & Son
Address Taneytown, Md.

19. Feb-13 1940 Ethel M Mehring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1940, at 8 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 , to Feb. 10 1940, and that I last saw him alive on Feb. 10 1940.

Immediate cause of death	DURATION
Coronary Occlusion	3 wks.
Due to	
Due to	
Other conditions Chronic Myocarditis	Several yrs
Chronic Nephritis	"

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M.D.
M. D. or other
Address Taneytown Md Date signed 2/12/40

RECEIVED
MAR 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

01690

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Finksburg Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 85 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Finksburg Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Annie Brandenburg

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife ~

6(c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1869

8. AGE:

Years	Months	Days	If less than one day
70	6	0	hrs. min.

9. Birthplace Hoods Mills, Carroll Co. Md.
(Town, county, and state)

10. Usual occupation House Keeper

11. Industry or business Own Home

FATHER
12. Name Jacob Brandenburg
13. Birthplace Md.

MOTHER
14. Maiden name Martha Dorsey
15. Birthplace Md.

16. Informant Geo. Brandenburg
Address Finksburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-14-40 (month) (day) (year)
Cemetery or crematory Oakland Cemetery
Location Oakland Road Md.

18. Funeral director C. Harry Weer
Address Reisterstown Md.

19. 2/13 19 40 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1940 at 9:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1940 to February 1940 and that I last saw h[illegible] alive on February 1940

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to Arteriosclerosis	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address Reisterstown Md. Date signed 2/13/40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

01691

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll Co
City or town: Union Bridge, R#4
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): Life time

2. USUAL RESIDENCE (HOME) OF DECEASED: None
(For newborn infants give residence of mother)
State: County:
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: ~~Charles George Harvey~~ Dillon Brooks
3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Married

6 (b) Name of husband or wife: Jennie Brooks
Living 6(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Carroll Co

8. AGE:

Years	Months	Days	If less than one day
71			hrs. min.

9. Birthplace: Carroll Co
(Town, county, and state)
10. Usual occupation: Labor or Farmer
11. Industry or business
FATHER 12. Name: Stephen Brooks
13. Birthplace: Carroll Co
MOTHER 14. Maiden name: Catherine Jobes
15. Birthplace: Carroll Co
16. Informant: Howard Davis
Address: Union Bridge Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 5 - 40 (month) (day) (year)
Cemetery or crematory: Mt Joy
Location: Union Town Md
18. Funeral director: Raymond K. Wright
Address: Union Bridge, Md
19. Feb. 3 1940 (Date rec'd by registrar) Eichman Registrar

MEDICAL CERTIFICATION Front

20. DATE OF DEATH: Feb 3 1940, at 5A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__,
and that I last saw h__ alive on ____ 19__.

Immediate cause of death: Cerebral Hemorrhage — DURATION
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jos. T. Marsh Deputy Medical Examiner
M. D. or other
Address: New Windsor Md Date signed: 7/3/40

RECEIVED
MAR 8 1919
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01692

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 5 yrs. 10 Mos. 13 das.

Stay in this community (yrs., or mos., or days): (Above.)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1369 N. Calhoun St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: James Brown

3. (b) Social Security Number: --

4. Sex: Male

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Single

B (b) Name of husband or wife: --

6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): Feb. 28, 1906

8. AGE: Years: 33 Months: 11 Days: 15 If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER

12. Name: William Brown

13. Birthplace: Winston Salem, N. C.

MOTHER

14. Maiden name: Elizabeth Austin

15. Birthplace: North Carolina

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-14-1940 (month) (day) (year)

Cemetery or crematory: Mt Calvary.

Location: A. A. Co. Md

18. Funeral director: Thomas E. Kelson.

Address: 1303 Presstman St

19. 2/11/40 (Date rec'd by registrar) 19 Albert R. Swankhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 11, 1940 12:10 A.M. 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30, 1934 19 , to Feb. 11, 1940 , and that I last saw him alive on Feb. 11, 1940 19

Immediate cause of death: Acute Cardiac Failure-- Auricular fibrillation

Due to: Pulmonary Tuberculosis

Due to: --

Other conditions: ---

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: No Autopsy

DURATION: 2 days Nov. 1931

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: -

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: - Injured at work? -

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 2/11/40

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-A)

CERTIFICATE OF DEATH

01693

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days): 6 yr. 7 mo. 1 day

Stay in this community (yrs., or mos., or days): 6 yr. 7 mo. 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Stratford Apartments
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: William D. Burall

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Leeanna Harrison

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 19, 1861

8. AGE: Years	Months	Days	If less than one day
78	7	25	hrs. min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Building Industry

FATHER
12. Name: William Burall
13. Birthplace: Maryland

MOTHER
14. Maiden name: ?
15. Birthplace: Maryland

16. Informant: Hospital Record

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 15th, 1940 (month) (day) (year)

Cemetery or crematory: Prospect Cem.

Location: Frederick Co., Md.

18. Funeral director: C.H.Weer

Address: Sykesville, Md.

19. Feb. 13th, 19 40 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13, 1940, at 11:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1938, to February 13, 1940, and that I last saw him alive on Feb. 13, 1940.

	DURATION
Immediate cause of death: Cerebral hemorrhage	Sudden
Due to: Cerebral Arteriosclerosis	1933
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Samuel Bankoff M.D. M.D. or other

Address: Springfield State Hospital Sykesville, Md. Date signed: 2/13/40

FEB 16 1940
BUREAU V.S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01694

(158)

1. PLACE OF DEATH

County Carroll Registration Dist. No. 76

Village or City Finksburg No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Sevey Winfield Copper If U. S. Veteran, specify WAR no

(a) Residence: No. Finksburg Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE Wh

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single boy

6. DATE OF BIRTH (month, day, and year) Jan. 26, 1940

7. AGE Years X Months 20 Days 14 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. boy

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Finksburg (State or country) Carroll Co

FATHER

13. NAME Winfield Copper

14. BIRTHPLACE (city or town) Carroll Co Md (State or country)

MOTHER

15. MAIDEN NAME Emma Finksburg

16. BIRTHPLACE (city or town) Balto Co (State or country)

17. INFORMANT Winfield Copper (Address) Finksburg

18. BURIAL, CREMATION, OR REMOVAL Place Providence Cem Date Feb 1st, 1940

19. UNDERTAKER J. F. Elmer Sr. (Address) Reisterstown

20. FILED 2/10, 1940 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb (Month) 10th (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 25th, 1940 to Feb 10th, 1940 I last saw him alive on Feb 2nd, 1940; death is said to have occurred on the date stated above, at 5 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Date of onset

Pneumonia Jan 26

Inability to take nourishment

Other Contributory Causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury .....

Nature of Injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) J. Frank Mottle M. D.

(Address) Reisterstown Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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MAR 5 1940
BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

01695

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton,
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch.

Stay in hospital or inst. (yrs., or mos., or days) 2 days

Stay in this community (yrs., or mos., or days) Above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 260 S. Bethel St.,
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Clark

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife ---

--- 6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 57 | Months ? | Days ? | If less than one day ____ hrs. ____ min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual occupation Unknown

11. Industry or business Unknown

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Reuben Hoffman, M. D.

Address Henryton, Md.

17. City (Burial, cremation, or removal, Which?) Date thereof Jan 9 40 (month) (day) (year)

Cemetery or crematory ~~Cemetery~~ City Morgue

Location Baltimore Md.

18. Funeral director Mrs Frances A Hemsley.

Address 578 W Biddle St.

19. 2/9/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Dep Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1940, at 3.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb., 7, 1940, to Feb., 9, 1940, and that I last saw him alive on February 9, 1940.

Immediate cause of death: Pulmonary Tuberculosis

Due to --

Due to ----

Other conditions ----
(Include pregnancy within 3 months of death)

Major findings:

Of operations ----

Of autopsy No Autopsy

DURATION: Jan., 1940

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ---- Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Maryland Date signed 2/9/40

RECEIVED
MAR 4 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

01696

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 79

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs Susan T. Crapster

3. (b) Social Security Number none

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced widow

6 (b) Name of husband or wife Wm W. Crapster

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1860

8. AGE: Years 79 Months 8 Days 6 If less than one day hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Thomas Longley

13. Birthplace Md

MOTHER 14. Maiden name Mary Galt

15. Birthplace Md

16. Informant Mrs Alice Cox

Address Washington D.C.

17. Burial Date thereof Feb 26 '40.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Piney Creek Presbyterian

Location Nr Taneytown, Md

18. Funeral director C O Fuss & Son

Address Taneytown, Md.

19. Feb 26 1940 Ethel M McKay
(Date rec'd by registrar) Registrar

(26)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24th 1940, at 10.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1924, to Feb. 23 1940, and that I last saw her alive on Feb. 23 1940.

Immediate cause of death Thrombosis of left femoral artery — DURATION 1 month

Due to Arteriosclerosis — 16 yrs.

Due to

Other conditions Chronic myo-Carditis — 5 yrs.
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Francis T. Elliot, M.D.
M. D. or other

Address Taneytown, Md. Date signed 2/25/40

RECEIVED
MAR 2 1910
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01697

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch, Henryton

Stay in hospital or inst. (yrs., or mos., or days): 2 Yrs. 8 Mos. 6 Days

Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1611 N. Carey St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: Charles Henry Davis

3. (b) Social Security Number: 216-07-6563 - Ross

4. Sex: Male

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henrietta Davis

6 (c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): Aug. 19, 1893

8. AGE: Years: 46 Months: 4 Days: 23 If less than one day: ___ hrs. ___ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: --

FATHER
12. Name: Samuel Davis
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Emma Gross
15. Birthplace: Baltimore, Md.

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-15-40 (month) (day) (year)

Cemetery or crematory: Randallstown Md.

Location: Baltimore County

18. Funeral director: George Kelson

Address: 1303 Preston St.

19. 2/14/40 (Date rec'd by registrar) 19 Albert R Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 13, 1940 19 11:40 P.M., at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7, 1937 19 to Feb. 13, 1940 19, and that I last saw him alive on Feb. 13, 1940 19

Immediate cause of death: Pulmonary Tuberculosis

Due to: --

Due to: --

Other conditions: ---
(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: No Autopsy

DURATION: Feb. 1937

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: --- Date of: --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 2/14/40

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01698

Reg. Dist. No. 74

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 1 Mo. 3 Days

Stay in this community (yrs., or mos., or days): (Same as Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 440 St. Mary's St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: Pinkney Davis

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife: ---

6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): March 10, 1916

8. AGE:

Years	Months	Days	If less than one day
23	11	19	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Reads Drug Store

FATHER
12. Name: Pinkney Davis
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Marie Bates
15. Birthplace: Baltimore, Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Md.

17. removal. (Burial, cremation, or removal. Which?) Date thereof Mar 5 1940 (month) (day) (year)

Cemetery or crematory: Pozzoni's A.C.

Location: Pozzoni's A.C.

18. Funeral director: R. Hahn & Son

Address: 9 E. Saratoga St. Balto.

19. 2/29/40 (Date rec'd by registrar) Albert R. Swankhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 29, 1940 19--, at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 26, 1940 19-- to Feb. 29, 1940 19--, and that I last saw h im alive on Feb. 29, 1940 19--.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: July 1938

Due to: ---

Due to: ---

Other conditions: ---

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: No autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Maryland Date signed: 2/29/40

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-a)

01699

CERTIFICATE OF DEATH

Reg. Dist. No. 7(6)

1. PLACE OF DEATH:

County Carroll

City or town rural near Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 18 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Washington Irving Dice

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Lucy Ellen Read

6(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) May 11, 1863

8. AGE: Years	Months	Days	If less than one day
76	9	3	____hrs. ____min.

9. Birthplace Uniontown, Ohio
(Town, county, and state)

10. Usual occupation Minister of the Gospel

11. Industry or business (retired)

FATHER 12. Name William B. Dice

13. Birthplace Ohio

MOTHER 14. Maiden name Sophia Coleman

15. Birthplace Ohio

16. Informant Lucy Ellen Dice

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 16, 1940 (month) (day) (year)

Cemetery or crematory Pleasant Grove Cemetery

Location Sandyville, Md.

18. Funeral director J. Francis Reese

Address Westminster, Md.

19. 2/14 (Date rec'd by registrar) 19 40 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14th 1940, at 2 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1st 1935 to Feb. 14th 1940, and that I last saw him alive on Feb. 14th 1940

Immediate cause of death Acute dilatation of heart — DURATION 2 hours

Due to Aortic Regurgitation — 10 yrs.?

Due to —

Other conditions Senility

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. F. Billingsley M. D. or other

Address Westminster, Md. Date signed 2/14/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 5 1940
BUREAU V. S.

01700

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 10 yr. 2 mos. 28 days

Stay in this community (yrs., or mos., or days) 10 yr. 2 mos. 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 2530 Boyd Street
(If rural give LOCATION)

(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Frederick Dietzel

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna C. ?

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) August 28, 1877

8. AGE:

Years	Months	Days	If less than one day
62	6	31	hrs. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Butcher

11. Industry or business

FATHER
12. Name Christian Dietzel
13. Birthplace Germany

MOTHER
14. Maiden name Laubretta Koch
15. Birthplace Germany

16. Informant Hospital Record

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-29-40 (month) (day) (year)

Cemetery or crematory London Park cemetery

Location Frederick Ave.

18. Funeral director G. B. Wippert

Address 1300 Eutaw Place Balto.

19. 2-28-40 19 (Date rec'd by registrar) Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28, 1940, at 8:15 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1, 1938, to Feb. 28, 1940, and that I last saw him alive on Feb. 27, 1940.

Immediate cause of death Cerebral Arteriosclerosis — DURATION 13 yrs.

Due to Arteriosclerosis

Probably cerebral hemorrhage. Patient had had several previous cerebral accidents. C.W.R.

Due to

Other conditions Psychosis with Cerebral Arteriosclerosis, and right hemiplegia. 1929
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Barkoff M.D. M. D. or other

Address Sykesville, Md Date signed 2/28/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01701

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 8 Mos. 22 days
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimre Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 721 Harlem Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Douglas

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife: ---
6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): Oct. 29, 1926

8. AGE:

Years	Months	Days	If less than one day
13	2	10	---hrs. ---min.

8. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business

FATHER
12. Name: Fred Douglas
13. Birthplace: Merryhill, N. C.

MOTHER
14. Maiden name: Sally White
15. Birthplace: Merryhill, N. C.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof 2/12/40 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cemetery
Location: Balto Md.
18. Funeral director: Mrs Kate R Williams
Address: 322 n Schroeder St
19. 2/7/40 (Date rec'd by registrar) Albert R. Swanbeck Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 7, 1940 19---, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1939 19---, to Feb. 7, 1940 19---, and that I last saw her alive on Feb. 7, 1940 19---.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1939
Due to: --
Due to: --
Other conditions: --
(Include pregnancy within 3 months of death)
Major findings:
Of operations: --
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of: -
Where did injury occur? (City or town) -- (County) -- (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? -

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 2/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01702

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Rural near Westminster Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 2 mos. 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll Co.

City or town Rural near Westminster Ward No. Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. X near Baughmans Church
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR X

3. (a) FULL NAME Mertie Jane Eckenrode

3. (b) Social Security Number X

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife X

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec. 2nd. 1939

8. AGE:

Years	Months	Days	If less than one day
X	2	21	____ hrs. ____ min.

9. Birthplace near Westminster Carroll Co. Md.
(Town, county, and state)

10. Usual occupation X

11. Industry or business X

FATHER
12. Name George W. Eckenrode
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden name Luella Elizabeth Naugle
15. Birthplace Frederick Co. Md.

16. Informant George W. Eckenrode
Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 25 40 (month) (day) (year)

Cemetery or crematory Friends Creek Cem.

Location near Emmitsburg Md.

18. Funeral director J. E. Myers Jr.

Address Westminster Md.

19. 2/24 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 3 1940, at 6a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 16 1940 to Feb 23 1940, and that I last saw her alive on Feb. 19 1940.

Immediate cause of death	DURATION
Broncho-pneumonia	5 Days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C Reese Wilbers M. D. or other

Address Westminster Date signed

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01703

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days) 8 yrs., 4 mos., 29 days.
Stay in this community (yrs., or mos., or days) Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland. County:
City or town: Baltimore, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1700 Eutaw Place.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Silas Fleischer.

3. (b) Social Security Number: #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	Married.

6 (b) Name of ~~husband~~ wife: Unknown.
6(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Unknown.

8. AGE:

Years	Months	Days	If less than one day
79	Unk.	Unk.	____ hrs. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Merchant.
11. Industry or business: Notions.
FATHER 12. Name: Emmanuel Fleischer.
13. Birthplace: Germany.
MOTHER 14. Maiden name: Theresa Strauss.
15. Birthplace: Germany.
16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-28-40 (month) (day) (year)
Cemetery or crematory: Balto. Hebrew Cemetery
Location: Balto. Md.
18. Funeral director: David J. Sindheim & Son
Address: 1902 Eutaw Place
19. 2-27-40 (Date rec'd by registrar) 19 ____ C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27, 1940, at 1 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 29, 1931, to Feb. 27, 1940, and that I last saw him alive on Feb. 27, 1940.

Immediate cause of death: Acute Broncho-Pneumonia — DURATION: 2-26-40
Due to:
Due to:
Other conditions: Chronic Myo-carditis prior to 9-29-31.
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy: No.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M.D., M. D. or other
Address: Sykesville, Md. Date signed 2-27-40.

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-a)

Reg. Dist. No. 71

01704

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Rural Wakefield (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 15 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME William Oscar Fox

3 (b) If veteran, name war no

3 (c) Social Security No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mary C Fox

6. (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) July 26th 1872

8. AGE: Years 67 Months 7 Days — If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name Jacob Fox

13. Birthplace Md

MOTHER

14. Maiden Name Emily Lookingbill

15. Birthplace Md

16 (a) Informant Mrs Mary C Fox

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 29 1940 (month) (day) (year)

(c) Cemetery or crematory Beaver Dam

Location near Union Bridge

18 (a) Funeral director Powell & Albaugh

(b) Address Liberty town Md

19 (a) Feb. 27, 40 (Date rec'd by registrar) (b) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. Date of death 2/26 1940, at 12.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7, 1939, to Feb. 26, 1940, and that I last saw him alive on February 26, 1940.

Immediate cause of death	Duration
Arterio Sclerosis	1939
Myocarditis	2-18-40
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. Sterling Gratty M. D. or other

Address New Windsor, Md Date signed 2-27-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 80 01705

1. PLACE OF DEATH:

County Carroll

City or town New Windsor outside (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Carroll

City or town Rural near Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. New Windsor (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Kenneth Woodrow Fritz

3. (b) Social Security Number 218-10-3484

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10 1918

8. AGE: Years 21 Months 5 Days 26 If less than one day hrs. min.

9. Birthplace Inwood Md (Town, county, and state)

10. Usual occupation Track Man

11. Industry or business W. M. R.R.

FATHER 12. Name Hollie Fritz

13. Birthplace Carroll Co Md

MOTHER 14. Maiden name Carrie Mae Flickinger

15. Birthplace Carroll Co Md

16. Informant Hollie Fritz

Address New Windsor Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 8-40 (month) (day) (year)

Cemetery or crematory Greenwood Cem.

Location Near New Windsor Md

18. Funeral director D D Hartzler Mgr

Address New Windsor Md

19. Feb 7 1940 (Date rec'd by registrar) Erwin Burbt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1940, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1939, to Feb 6 1940, and that I last saw him alive on Feb 4 1940.

Immediate cause of death Pulmonary Tuberculosis — DURATION 3 yrs

Due to

Due to

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations Non

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of Injury — Injured at work? —

23. SIGNATURE Jas. T. March M. D. M. D. or other

Address New Windsor Md Date signed 2/6/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

93-1

01706

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH:
County Carroll
City or town New Windsor, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town New Windsor Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Pearl L. Fritz

3. (b) Social Security Number 219-05-7256

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Married
6 (b) Name of husband ~~or wife~~ Grover C. Fritz
6 (c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) June 6 - 1884
8. AGE: Years 55 Months 8 Days 13 If less than one day hrs. min.
9. Birthplace Pleasant Hill Md.
(Town, county, and state)
10. Usual occupation Housewife B.F. Shriver
11. Industry or business ~~Own Home~~ Co Canners
FATHER
12. Name Isaah Greenwood
13. Birthplace New Windsor, Md.
MOTHER
14. Maiden name Ida Horton
15. Birthplace Taylorsville, Md.
16. Informant Grover C. Fritz
Address New Windsor, Md
17. Burial Date thereof Feb. 21-40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenwoods Cem.
Location Near New Windsor Md.
18. Funeral director W. W. Hartzler & Sons
Address New Windsor Md.
19. Feb 21 19 40 Ernest S. Bruder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1940, at 5 p M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-14- 1940, to 2-19- 1940, and that I last saw her alive on 2-14- 1940.
Immediate cause of death Chronic Myocarditis
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Dt operations
Dt autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE T. H. Legg M. D. or other
Address Union Bridge Date signed 2-21-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(107)

01707

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 yr. 3 mo. 18 da

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1415 Hall St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

1930 Dec Dept

3. (a) FULL NAME Margaret Gallagher

3. (b) Social Security Number /

4. Sex: Female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years 83 | Months / | Days / | If less than one day ___ hrs. ___ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Dressmaker

11. Industry or business

FATHER
12. Name Michael Gallagher
13. Birthplace Ireland

MOTHER
14. Maiden name Mary Nolan
15. Birthplace Ireland.

16. Informant Rose Raley

Address 227 Hopkins Ave

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof 2/19/40 Baltimore
(month) (day) (year)

Cemetery or crematory New Cathedral

Location Old Frederick Rd

18. Funeral director John J. Fahey & Sons

Address 1318 Light St

19. 2-15-40 19 Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14th 1940, at 445 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 26 1938, to Feb 14 1940, and that I last saw her alive on Feb 14th 1940.

Immediate cause of death Bronchopneumonia

Due to

Due to Generalized arterio sclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

DURATION: Feb 6 40; 15 yrs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. Martin
M. D. or other

Address Sykesville Md Date signed Feb 14 40

RECEIVED
MAR 4 1940
BUREAU V. S.

01708

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 8 days

Stay in this community (yrs., or mos., or days): 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 3611 White Avenue
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: William Henry Garrett

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Not known

6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): December 1, 1862

8. AGE: Years 77 | Months 2 | Days 21 | If less than one day ___ hrs. ___ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Boiler maker and inspector

11. Industry or business

FATHER
12. Name: James Garrett
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Jane Baker
15. Birthplace: Maryland

16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address

17. Moreland Pk
(Burial, cremation, or removal. Which?)
Date thereof: Feb 24-1940 (month) (day) (year)

Cemetery or crematory: Burial

Location: Parkville, Md

18. Funeral director: William Cook

Address: 1217 St Paul Street

19 2-23-40 (Date rec'd by registrar) 19 C Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22nd 1940, at 7:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14th 1940, to February 22, 1940 and that I last saw him alive on February 22nd, 1940.

Immediate cause of death	DURATION
General arteriosclerosis	Known 2/14/40
Due to	
Due to	
Other conditions: Cerebral hemorrhage	1/7/40

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy: Coronary Heart Disease with old cardiac infarct. 2/23/40

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D. M. D. or other

Address: Sykesville, Md Date signed: Feb. 23-1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 24 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01709

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days) 10 yr. 2 mos.
Stay in this community (yrs., or mos., or days) 10 yr. 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 206 N. High Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harry Aaron Goldner

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Married ?
6 (b) Name of husband or wife ?
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years ~~51~~ 45 Months Days If less than one day hrs. min.

9. Birthplace Russia (Town, county, and state)
10. Usual occupation Tailor
11. Industry or business Clothing

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant Hospital Record.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-21-40 (month) (day) (year)
Cemetery or crematory Ohb Shalom
Location O'Donnel St.
18. Funeral director Jack Lewis Inc
Address Balto & Caroline Sts Balto
19. 2-19-40 (Date rec'd by registrar) 19 C Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19, 1940 19 6:45 a.m. at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 19 38, to February 19 19 40, and that I last saw him alive on Feb. 18, 19 40.

Immediate cause of death Coronary occlusion
Due to Arteriosclerosis
Due to
Other conditions General paralysis of the insane
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION
About five minutes
16 yr.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel Barkoff M.D. M. D. or other
Address Sykesville, Md Date signed 2/19/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01710

Reg. Dist. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Rural m. Mt. Olive Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 18 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural m. Mt. Olive Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.D. Mt. Airy, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No.

3. (a) FULL NAME William Henry Gosnell

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

6 (b) Name of husband or wife Late Sarah E. Gosnell.

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1852

8. AGE:

Years	Months	Days	If less than one day
87	3	3	____ hrs. ____ min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Retired Farmer.

11. Industry or business

FATHER

12. Name William H. Gosnell.

13. Birthplace Maryland.

MOTHER

14. Maiden name ~~Emily~~ Ruth Slatterwood.

15. Birthplace Maryland.

16. Informant Mrs. Curtis Penn

Address R.D. Mt. Airy, Md.

17. Burial Date thereof Feb. 12, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olive

Location Mt. Olive Carroll Co. Md.

18. Funeral director C.M. Waltz

Address Winfield, Md

19. Feb. 9 1940 E. M. Farver
(Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8th 1940, at 7:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 4 1940, to Feb 8 1940, and that I last saw him alive on Feb 7 1940.

Immediate cause of death	DURATION
Terminal Pneumonia	
Due to Chronic Nephritis	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. Van Poole
M. D. or other

Address Mt Airy Md Date signed 1-9-40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

CERTIFICATE OF DEATH

01711

Reg. Dist. No. 7-5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Near Millers
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 37 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Near Millers Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary E. Graf

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John L. Graf
6(c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Jan. 9. 1859

8. AGE:

Years	Months	Days	If less than one day
81	1	1	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Housework
FATHER 12. Name Christian F. Hunt
13. Birthplace Germany
MOTHER 14. Maiden name Catherine Hirshman
15. Birthplace Germany
16. Informant Mrs. Jessie Hare
Address Hanoverstead Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 13, 1940 (month) (day) (year)
Cemetery or crematory cemetery
Location Manchester Md
18. Funeral director Jacob Wentz's Sons
Address Manchester. Md.
19. Feb. 12 1940 Mrs. W. P. S. Denver
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 Th 1940, at 5 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10th 1940, to Feb 10 th 1940
and that I last saw h- alive on Feb 10 th 1940

	DURATION
Immediate cause of death Chronic myocarditis	2 years
Due to	
Due to	
Other conditions Senility of age	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy No autopsy.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. M. Resh M.D.
M. D. or other
Address Hampstead Md Date signed 2/14/40

RECEIVED
MAR 5 1940
BUREAU V. S.

01712

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium

Stay in hospital or inst. (yrs., or mos., or days) 1 Mo. 4 Days

Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 654 W. Fairmount Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR --

3. (a) FULL NAME Annie Bell Gray

3. (b) Social Security Number --

4. Sex: Female

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ---

6(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) May 14, 1914

8. AGE: Years 15 | Months 8 | Days 27 | If less than one day ___ hrs. ___ min.

9. Birthplace Spartanburg, S. C.
(Town, county, and state)

10. Usual occupation Scholar

11. Industry or business ---

FATHER
12. Name Willie Gray
13. Birthplace Spartanburg, S. C.

MOTHER
14. Maiden name Jeanette Wooduff
15. Birthplace Spartanburg, S. C.

16. Informant Dr. Reuben Hoffman

Address Henryton, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 2-14-40 (month) (day) (year)

Cemetery or crematory Mt. Auburn

Location Mt. Winans

18. Funeral director Mrs. Katie R. Williams

Address 322 N. Schroeder St.

19. 2/10/40 (Date rec'd by registrar) 19 Albert R. Swankhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1940 19 2:45 A.M., at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6, 1940 19 , to Feb. 10, 1940 19 , and that I last saw her alive on Feb. 10, 1940 19

Immediate cause of death: Pulmonary Tuberculosis

Due to --

Due to ---

Other conditions ---
(Include pregnancy within 3 months of death)

Major findings:

Of operations --

Of autopsy No Autopsy

DURATION: April 1939

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 2/10/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01713

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 1 yr. 5 Mos. 1 day

Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Charles Co.

City or town Malcolm Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harrison Roosevelt Greenfield

3. (b) Social Security Number --

4. Sex: Male

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Single

B (b) Name of husband or wife --

6(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) June 15, 1903

8. AGE: Years 36 | Months 7 | Days 23 | If less than one day ___ hrs. ___ min.

9. Birthplace Malcolm, Md. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business --

FATHER

12. Name John E. Greenfield

13. Birthplace Malcolm, Md.

MOTHER

14. Maiden name Levenia Edelen

15. Birthplace Malcolm, Md.

16. Informant Dr. Reuben Hoffman

Address Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/10/40 (month) (day) (year)

Cemetery or crematory St. Peter's

Location Waldorf, Md

18. Funeral director Hunett & Ryan

Address Waldorf, Md.

19. 2/7/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1940 19 7:00 Am. at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 31, 1938 19 to Feb. 7, 1940 19

and that I last saw him alive on Feb. 7, 1940 19

Immediate cause of death: Pulmonary Tuberculosis

DURATION: Dec. 1937

Due to --

Due to --

Other conditions --

(Include pregnancy within 3 months of death)

Major findings:

Of operations ---

Of autopsy No Autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 2/7/40

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MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

CERTIFICATE OF DEATH

01714

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 1 Webster Street

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): life

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1 Webster (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Alice Jane Groft

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife: Charles L. Groft

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 13, 1863

8. AGE:

Years	Months	Days	If less than one day
76	4	10	hrs. min.

9. Birthplace: Westminster, Md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: John Q. Miller

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Amanda Frock

15. Birthplace: Maryland

16. Informant: Mrs. Roland Armacost

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2/26/40 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 2/26/40 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23, 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940 to Feby 22 1940 and that I last saw h[illegible] alive on Feby 23rd 1940.

	DURATION
Immediate cause of death: acute cardiac dilatation	18 hrs
Due to: myocarditis	Jan 1940
Due to: arterio sclerosis	5 yrs
Other conditions: chronic cholecystitis	10 yrs

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas R Fouty M D

M. D. or other

Address: Westminster Date signed 2/24/40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01715

Reg. Dist. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Westminster Rural
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Near Gypsy Hill

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Near Gypsy Hill
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elaine Lois Haines

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 7 - 1940

8. AGE: Years | Months: 1 | Days: 10 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Walter T. Haines
13. Birthplace: Uniontown Md.

MOTHER
14. Maiden name: Mary Wantz
15. Birthplace: Pleasant Valley Md.

16. Informant: Walter T. Haines
Address: Westminster Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 18-1940 (month) (day) (year)

Cemetery or crematory: Pleasant Valley Cem.

Location: Near Pleasant Valley

18. Funeral director: H. C. Bartlett & Sons

Address: New Windsor, Md.

19. Feb. 17-1940 (Date rec'd by registrar) E. M. Farver Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby. 17th 1940, at 2.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 16th 1940, to Feby 17th 1940, and that I last saw her alive on Feby 17th 1940.

	DURATION
Immediate cause of death	
Influenza	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. L. Stitely
M. D. or other

Address New Windsor Date signed Feby 17th 40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01716

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Coloed Branch

Stay in hospital or inst. (yrs., or mos., or days): 20 days

Stay in this community (yrs., or mos., or days): (above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Annapolis Junction Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: James Hall

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife: ---

6(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.): June 1, 1886 (?)

8. AGE: Years: 53 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Laurel, Maryland.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER
12. Name: George Hall
13. Birthplace: Unknown

MOTHER
14. Maiden name: Julie Johnson
15. Birthplace: Washington, D. C.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 3/3/40 (month) (day) (year)

Cemetery or crematory: Bacons cemetary

Location: Laurel Md.

18. Funeral director: W. C. White Co.

Address: Laurel Md.

19. 2/28/40 (Date rec'd by registrar) Albert R. Swankhouse Deputy Local Registrar

MEDICAL CERTIFICATION

12.30

20. DATE OF DEATH: February 28, 1940, at A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 9, 1940, to Feb., 28, 1940, and that I last saw him alive on February 28, 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct., 1939
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ----

Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other

Address: Henryton, Md. Date signed 2/28/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01717

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 4 Mos. 16 days
Stay in this community (yrs., or mos., or days): (Same as Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Geo's
City or town: Upper Marlboro Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: –
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Matilda Ruth Hamilton

3. (b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife: Asbury Hamilton
6(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): Feb. 22, 1911

8. AGE: Years	Months	Days	If less than one day
29	No	2	____ hrs. ____ min.

9. Birthplace: Upper Marlboro, Md. (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: – –

FATHER
12. Name: Dennis Smith
13. Birthplace: Prince George Co., Md.

MOTHER
14. Maiden name: Edda Hearbon,
15. Birthplace: Upper Marlboro, Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-27-40 (month) (day) (year)
Cemetery or crematory: Woodmore
Location: Woodmore, Md.

18. Funeral director: Clarence Foreacre
Address: Mitchellville, Md.

19. Feb. 24, 1940 (Date rec'd by registrar) Albert R. Swanhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 24, 1940 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 18, 1939 to Feb. 24, 1940, and that I last saw her alive on Feb. 24, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1939
Due to: – – –	
Due to: – –	
Other conditions: – – –	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: – – –
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: – – Date of:
Where did injury occur? – – – (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): – – –
Means of injury: – – Injured at work? – –

23. SIGNATURE: Reuben Hoffman, M. D. (M. D. or other)
Address: Henryton, Maryland Date signed: 2/24/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

01718

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or instl. (yrs., or mos., or days) 1yr., 11mo., 22 days
Stay in this community (yrs., or mos., or days) 1yr., 1mo., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Lydia A. Harris

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nathan Harris

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1860

8. AGE: Years: 80 | Months | Days | If less than one day: ____ hrs. ____ min.

9. Birthplace: Carroll Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Henry Richter
13. Birthplace: Germany

MOTHER
14. Maiden name: Margret Bloom
15. Birthplace: Germany

16. Informant: Mrs. Chas. Pickell
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-1-40 (month) (day) (year)
Cemetery or crematory: Deer Park Cemetery
Location

18. Funeral director: A. Bankard & Son
Address: Westminster, Md.

19. 2-29-40 (Date rec'd by registrar) C. Harry Weer, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 28 1940, at 8:10 A.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Jan. 6, 1939, to Feb. 28, 1940, and that I last saw her alive on Feb. 27 1940.

	DURATION
Immediate cause of death: Myocardial degeneration	4 yrs.
Due to: Hypertensive cardiovascular disease	4 yrs.
Due to: Arteriosclerosis, generalized	4 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. (M. D. or other)
Address: Springfield State Hospital Date signed 2-28-40

RECEIVED
MAR 4 1910
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01719

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 32 yrs, 10 mos, 17 days

Stay in this community (yrs., or mos., or days): 32 yrs, 10 mos, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Centreville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Minnie Hartman

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1874

8. AGE:

Years	Months	Days	If less than one day
66			____ hrs. ____ min.

9. Birthplace: near Hagerstown, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: George Hartman
13. Birthplace: Bavaria

MOTHER
14. Maiden name: Regina Stok
15. Birthplace: Germany

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 10, 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Hagerstown Md

18. Funeral director: F. K. Hoffman

Address: Hagerstown Md

19. 2-8-40 (Date rec'd by registrar) C. Harry Weer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 8 1940, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 1907, to Feb. 8 1940, and that I last saw her alive on Feb. 7 1940.

Immediate cause of death	DURATION
Hypostatic Pneumonia	3 days
Cerebral hemorrhage	3 days
Due to Hypertensive cardiovascular disease	7 years
Due to	
Other conditions: Mental deficiency	Life

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other

Address: Springfield State Hospital Date signed 2/8/40

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (83a)

01720

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Gamber
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) 2 yrs.
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Gamber Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Edith Harvey

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frank B. Harvey
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Sept. 17th 1876

8. AGE: Years 63 | Months 4 | Days 20 | If less than one day ____ hrs. ____ min.

9. Birthplace: New York (Town, connty, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Alonza T. Campbell
13. Birthplace: New York

MOTHER
14. Maiden name: ------- Crosby
15. Birthplace: New York

16. Informant: Frank B. Harvey
Address: Finksburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 12, 1940 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Washington, D.C.

18. Funeral director: C. H. Wear
Address: Sykesville Md.

19. 2/9 1940 L. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1940 19 6-30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/7 1940, to 2/7 1940, and that I last saw her alive on 2/7 1940.

Immediate cause of death: Sub arachnoid hemorrhage — DURATION 6 hrs
Due to: arachnoid
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. A. Barnes M.D. M. D. or other
Address Sykesville Md. Date signed 2/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

01721

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 28 yrs. 20 days

Stay in this community (yrs., or mos., or days) 28 yrs. 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. unknown

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Frank Herotek

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married ?

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 74 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Austria (Town, county, and state)

10. Usual occupation Silversmith

11. Industry or business ?

FATHER 12. Name Karl Herotek

FATHER 13. Birthplace Austria

MOTHER 14. Maiden name Marie Yellinek

MOTHER 15. Birthplace Austria

16. Informant Hospital Record

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-1-40 (month) (day) (year)

Cemetery or crematory Springfield Hosp. Cemetery

Location Sykesville Md.

18. Funeral director Harry Weer

Address Sykesville Md.

19. 2-29-40 (Date rec'd by registrar) 19 Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28, 1940, at 2:15 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 1 1938, to Feb. 28, 1940, and that I last saw him alive on Feb. 27, 1940.

Immediate cause of death Bronchopneumonia — DURATION 4 days

Due to ?

Due to

Other conditions Schizophrenia, Paranoid Type — 34 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Barkoff M.D. M. D. or other

Address Sykesville, Md. Date signed 2/28/40

RECEIVED
MAR 4 1958
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH to

2411 N. Charles St., Baltimore (83P)

01722

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 11yrs.1mo.22das.

Stay in this community (yrs., or mos., or days) Same

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. ?
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: MINNIE HUNTZBERGER

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 25,1879

8. AGE: Years 60 Months 1 Days 30 If less than one day hrs. min.

9. Birthplace ? ? ? Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Jacob Huntzberger
13. Birthplace Maryland

MOTHER
14. Maiden name Anna Wisewander
15. Birthplace Maryland

16. Informant Hospital Records

Address Sykesville,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 27 1940 (month) (day) (year)

Cemetery or cremafory Broadfording

Location near Hagerstown

18. Funeral director C M Sutter & Sons

Address Hagerstown Md

19. Feb 24 1940 (Date rec'd by registrar) C Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1940, 3;10AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan.9, 1939, to Feb.24 1940, and that I last saw her alive on Feb.23 1940.

Immediate cause of death Cerebral Thrombosis — DURATION 10 Das.

Due to Arteriosclerosis — 7 years

Due to

Other conditions Dementia Praecox — 24 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D. M. D. or other

Address Sykesville, Md Date signed Feb. 24-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

01723

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster near Rural
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 89 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Rural near Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Liberty Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Agnes R. Hymiller

3. (b) Social Security Number None

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced widow

6 (b) Name of husband ~~or wife~~ John N. Hymiller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4 - 1851

8. AGE: Years 89 Months — Days 7 If less than one day hrs. min.

9. Birthplace Westminster, Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Jesse Yingling
13. Birthplace Maryland

MOTHER
14. Maiden name Elizabeth Hoppe
15. Birthplace Maryland

16. Informant Richard Hymiller

Address Liberty Street, Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 15 - 1940 (month) (day) (year)

Cemetery or crematory Mt. View Cemetery

Location Union Bridge, Maryland

18. Funeral director H. Bankard & Son

Address Westminster, Maryland

19. 2/12 1940 L. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12th 1940, at 3 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 1940, to Feb. 12 1940, and that I last saw he alive on Feb. 10th 1940.

Immediate cause of death Arteria Sclerosis

DURATION Many yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. K. Woodward M.D.
M. D. or other

Address Westminster Date signed 2/12/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

Richard Anthony Jones

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01724

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 19 days
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1900 E. Chase St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: Richard Anthony Jones

3. (b) Social Security Number: 216-09-5770

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife: --

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 19, 1904

8. AGE:

Years	Months	Days	If less than one day
35	9	30	hrs. min.

8. Birthplace: Hanover, Va. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Bethlehem Steel Co.
FATHER 12. Name: Frank Jones
13. Birthplace: Hanover Co., Va.
MOTHER 14. Maiden name: Mary Weatherless
15. Birthplace: Hanover Co., Va.
16. Informant: Dr. Reuben Hoffman
Address: Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/22/1940 (month) (day) (year)
Cemetery or crematory: Hurrey County, Va.
Location:
18. Funeral director: R.G. Elliott
Address: 129 N. Carroline St.
19. 2/18/40 (Date rec'd by registrar) Albert R. Swankhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 18, 1940 19 , at 4:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 31, 1940 19 to Feb. 18, 1940 19 and that I last saw him alive on Feb. 18, 1940 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1939
Due to: --	
Due to: --	
Other conditions: --	

(Include pregnancy within 3 months of death)
Major findings:
Of operations: --
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

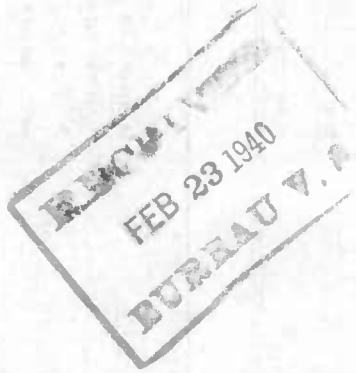
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 2/18/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


FEB 23 1940
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

01725

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Oakland Mills

City or town Carroll
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Oakland Mills Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elias R. Kelly

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth E. Kelly

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14th, 1856

8. AGE: Years	Months	Days	If less than one day
84	---	24	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name George Kelly
13. Birthplace Maryland

MOTHER
14. Maiden name Sarah Reed
15. Birthplace Maryland

16. Informant Elizabeth E. Kelly

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 10th, 1940 (month) (day) (year)

Cemetery or crematory Oakland

Location Carroll Co. Md.

18. Funeral director C. H. Weer

Address Sykesville, Md.

19. Feb. 8th 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 1940, at 12 10 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1938, to Feb. 8, 1940, and that I last saw him alive on Feb. 6, 1940

Immediate cause of death	DURATION
Chronic Valvular Heart Disease	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other

Address Randallstown Date signed 2/9/40

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01726

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 2 yrs., 9 mos., 26 days
Stay in this community (yrs., or mos., or days): 2 yrs., 9 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No.: 521 N. Pulaski (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Kuhn

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 19, 1848

8. AGE: Years	Months	Days	If less than one day
91	11	6	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Record from Spring Grove Hospital where formerly
Address: a pt.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 2 (month) 28 (day) 40 (year)
Cemetery or crematory: Holy Redeemer
Location: Balto. Md.
18. Funeral director: E. W. Hamerman
Address: 1003 W. Balto St.

19 2-26-40 (Date rec'd by registrar) Harry Weer, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 25 1940, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 1937, to Feb. 25 1940, and that I last saw h er alive on Feb. 25 1940

Immediate cause of death	DURATION
Hypostatic pneumonia	5 days
Due to Hypertensive cardio-vascular disease	7 years
Due to Arteriosclerosis, generalized	7 years
Due to Abscess	
Due to	
Other conditions Abscess of buttock	15 days

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other
Address: Springfield State Hospital Date signed: 2-25-40

RECEIVED
FEB 29 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01727

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sykesville + Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 mo. 15 days

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 900 Patapsco Avenue
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Annie Kirby

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 1- 1875

8. AGE: Years: 64 | Months: 6 | Days: 10 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: William Thomas

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Barbara S Hubert

MOTHER 15. Birthplace: Unknown

16. Informant: Hospital Records

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 14 — 40 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Balto Md

18. Funeral director D F McCarty

Address 128 E. Fort Ave

19. Feb 12 19 40 (Date rec'd by registrar) C Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1940, at 4:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27 1939, to February 11 1940, and that I last saw her alive on February 11 1940.

Immediate cause of death: Arteriosclerosis — DURATION: 1929

Due to Chronic Myocarditis and — DURATION: Known

Due to Myocardial Degeneration — DURATION: Dec. 1939

Due to

Other conditions Cerebral Hemorrhage — DURATION: Nov. 1939.

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D.
M. D. or other

Address Sykesville, Md. Date signed Feb 11 1940

FEB 16 1940
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

01728

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Buchmans Valley
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town New Windsor Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaretta Lambert

3. (b) Social Security Number None

4. Sex F.

5. Color or race W

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17- 1861

8. AGE: Years 79 Months 0 Days 15 If less than one day hrs. min.

9. Birthplace New Windsor, Carroll, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name John Lambert
13. Birthplace Maryland

MOTHER
14. Maiden name Emily Jane Lambert
15. Birthplace Maryland

16. Informant Herbert Lambert

Address Finksburg Maryland

17. Burial Date thereof Feb. 4-1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Winters

Location near New Windsor, Md.

18. Funeral director H Bankard Son

Address Westminster, Md.

19. 2/2 1940 L. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2nd 1940, at 8 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15th 1940, to Feb. 2nd 1940, and that I last saw her alive on Feb. 1st 1940.

Immediate cause of death Uremic Poisoning

Due to Chron. Int. Nephritis

Due to Chron. Myocarditis

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION
2 days
1 yr

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C L Billingslee
M. D. or other

Address Westminster Date signed 2/2/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 15 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

01729

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll County

City or town: Sykesville, Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 6 mos. 2 days

Stay in this community (yrs., or mos., or days): 6 mos. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 2010 Westwood Avenue

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Nicholas Lambros

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Stella Feggar

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 28, 1883

8. AGE:	Years	Months	Days	If less than one day
	56	3	19	hrs. min.

9. Birthplace: Greece (Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business: Clothing

FATHER

12. Name: John Lambros

13. Birthplace: Greece

MOTHER

14. Maiden name: Pilia ?

15. Birthplace: Greece

16. Informant: Hospital Record.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2 18 40 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: Baltimore

18. Funeral director: F. A. Sharrer & Son

Address: Westminster Md.

19. 2-16-40 (Date rec'd by registrar) 19 Aubrey Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16, 1940 19 , at 4 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 14, 19 39, to February 16, 19 40 and that I last saw him alive on February 15, 19 40.

Immediate cause of death: Epithelioma of nasal antra with metastasis to brain. — DURATION: prior to 1937

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M.D. M. D. or other

Address: Sykesville, Md. Date signed: 2-16-40.

FEB 26 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01730

Reg. Dist. No. 7

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days) 13 years 7 mos 3 da
Stay in this community (yrs., or mos., or days) 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 3418 Piedmont Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME Harry Macht

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Nellie Macht
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 18, 1873

8. AGE:

Years	Months	Days	If less than one day
66	5	17	hrs. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Moses Macht
13. Birthplace: Russia

MOTHER
14. Maiden name: Esther —
15. Birthplace: Russia

16. Informant: Hospital Records
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 6 1940 (month) (day) (year)
Cemetery or crematory: Beth Tefilah
Location: Woodlawn Mills P.O.

18. Funeral director: Sol Levinson Bros
Address: 124 W North Ave

19. Feb. 4 1940 (Date rec'd by registrar) C. Harry Kees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1940, at 3:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 29 1939, to February 4 1940, and that I last saw him alive on February 3 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 30-1936
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

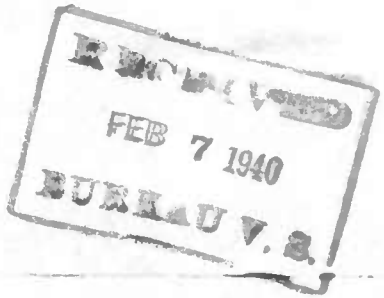
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE M. Virginia Beyer M.D.
M. D. or other
Address: Sykesville, Md. Date signed Feb. 4-1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


FEB 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01731

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch,
Stay in hospital or inst. (yrs., or mos., or days): 13 Days
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Edgewater Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: Susie Mackall

3. (b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femal	Colored	Married

6 (b) Name of husband or wife: Willi m Mackell
6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): Sept. 15, 1916

8. AGE: Years	Months	Days	If less than one day
23	4	26	____ hrs. ____ min.

9. Birthplace: Harwood, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: --

FATHER
12. Name: Henry Selman
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rosie Parker
15. Birthplace: Maryhnd

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 12 1940 (month) (day) (year)
Cemetery or crematory: Daniel Star
Location: West River
18. Funeral director: T. A. Hardesty & Son
Address: Galesville, Md.

19. 2/10/40 (Date rec'd by registrar) Albert R. Brookshire Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10, 1940 12/15 P.M. 19 ____, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 26, 1940 19 ____, to Feb. 10, 1940 19 ____, and that I last saw h -- or alive on Feb. 10, 1940 19 ____.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: No autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) -- (County) -- (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M. D. M. D. or other
Address: Henryton, Md. Date signed: 2/10/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

01732

CERTIFICATE OF DEATH

Reg. Dist. No. 72

1. PLACE OF DEATH:

County Carroll

City or town Westminster R.D.1 (Silver Run)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 21 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster, R.D.1 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Franklin Henry Manchey

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida (Kroh) Manchey

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) June-23-1865

8. AGE: Years 74 Months 8 Days 4 If less than one day ___ hrs. ___ min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation Carpentas (Retired 2 yrs)

11. Industry or business Buildings

FATHER
12. Name Valentine Manchey
13. Birthplace Maryland

MOTHER
14. Maiden name Henrietta Krumrine
15. Birthplace Maryland

16. Informant Mrs. Frank Manchey

Address Westminster R.D.I

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof March-1-1940
(month) (day) (year)

Cemetery or crematory Union Cemetery

Location Silver Run. Md.

18. Funeral director J. W. Little & Son

Address Littlestown PA. Per R.A.L.

19. Feb. 29th. 1940. Calvin E. Bankert, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27th 1940, at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 17th 1940, to Feb. 27th 1940, and that I last saw him alive on Feb. 27th 1940.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other conditions General Arterio Sclerosis Hypertension
(Include pregnancy within 8 months of death)

Major findings:

Of operations none

Of autopsy None

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry F. Poeken M.D.
M. D. or other

Address 17 E. King Littlestown Pa. Date signed 2/28/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 2 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(83-a)

01733

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll.

City or town Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital.

Stay in hospital or inst. (yrs., or mos., or days) 1 yr., 2 mos., 6 days.

Stay in this community (yrs., or mos., or days) Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland, County #

City or town Baltimore. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 705 Vanlill.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No record.

3. (a) FULL NAME Charles E. Mariner.

3. (b) Social Security Number 717-07-7815

4. Sex: Male. 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Married.

6 (b) Name of ~~husband or~~ wife Sophie Schreiner.

6(c) If alive, give age Unk. years

7. Birth date of deceased (mo., day, yr.) February 27, 1870.

8. AGE: Years 69. Months 11. Days 26. If less than one day ____ hrs. ____ min.

8. Birthplace Maryland.
(Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business Pennsylvania R. R.

FATHER
12. Name Charles W. Mariner.
13. Birthplace Unknown.

MOTHER
14. Maiden name Unknown.
15. Birthplace Unknown.

16. Informant Springfield Hospital Record.
Address Sykesville, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 2-26-40 (month) (day) (year)

Cemetery or crematory Mount Carmel.

Location Colonell St. Road.

18. Funeral director Wendell Lippel

Address 1406 Gough St.

19. 2-23-40 19 Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23, 1940, at 11 30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 17, 1938, to Feb. 23, 1940; and that I last saw him alive on Feb. 23, 1940.

Immediate cause of death: Cerebral Haemorrhage — DURATION 2-22-40

Due to Cerebral Arteriosclerosis prior to 12-17-38.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE Harry F. Baer, M. D.
M. D. or other

Address Sykesville, Md. Date signed 2-23-40.

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01734

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Hampstead Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME Walter LeRoy Marshall

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife ✓

6(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) March 1st 1918

8. AGE:

Years	Months	Days	If less than one day
21	11	18	____ hrs. ____ min.

9. Birthplace Near Greenmount, Carroll, Md.
(Town, county, and state)

10. Usual occupation Labor

11. Industry or business Farm Labor

FATHER 12. Name Winfred Marshall

13. Birthplace Maryland

MOTHER 14. Maiden name Sarah Hawkins

15. Birthplace Maryland

16. Informant Melvin Marshall

Address Manchester Md

17. Burial Date thereof Feb. 21-1940
(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Greenmount Md

18. Funeral director Jacob Wims & Son

Address Manchester Md.

19. 2/21 1940 C P Gagle
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1940, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. T. Shank, Deputy Medical Examiner
M. D. or other

Address New Windsor Md Date signed 2/19/40

FEB 29 1940
BUREAU

STATE OF MARYLAND—CERTIFICATE OF DEATH

01735

1. PLACE OF DEATH (131-a)

County Carroll Co Md Registration Dist. No. 71

Village or City Fuzzelburg Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mary A. Mason If U. S. Veteran, specify WAR

(a) Residence: No. State Rd. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Lloyd Mason

6. DATE OF BIRTH (month, day, and year) Sept 26 - 1862

7. AGE: Years 77 | Months 4 | Days 12 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. at Home

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Hampstead Md

FATHER

13. NAME Michael Snyder

14. BIRTHPLACE (city or town) (State or country) Carroll Co

MOTHER

15. MAIDEN NAME Betty Patterson

16. BIRTHPLACE (city or town) (State or country) Carroll Co

17. INFORMANT (Address) Lloyd Mason Fuzzelburg Md

18. BURIAL, CREMATION, OR REMOVAL Place Meadowbranch Date Sept 10 1940

19. UNDERTAKER (Address) A. S. Marshall 3539 Falls Rd

20. FILED 2/10, 1940 Margaret R. Englar Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb. 8 — 1940 (Month) (Day) (Year)

22. I HEREBY CERTIFY That I attended deceased from Sept, 1937, to Feb. 8, 1940

I last saw her alive on Feb. 8, 1940; death is said to have occurred on the date stated above, at 11:20 a m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Myocarditis (Chr.)	
Nephritis (Chr.)	

Other Contributory Causes of importance:

Acute dilatation of heart.	2-8-40

Name of operation None Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? None (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) W. C. Jennette M. D.

(Address) Westminster Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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MAR 5 1940
BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

01736

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 21 Hersh ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 2 hrs 15 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 21 Hersh ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Baby Girl Mayer

3. (b) Social Security Number —

4. Sex Female

5. Color or race W

6.(a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

— 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-28-1940

8. AGE: Years — Months — Days — If less than one day 2 hrs. 15 min.

9. Birthplace Westminster Carroll Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Gordon Mayer
13. Birthplace Balto City Md.

MOTHER
14. Maiden name Helen Tenkler
15. Birthplace Balto Co. Md.

16. Informant Gordon Mayer

Address Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 29, 1940 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster, Maryland

18. Funeral director H. Bankard & Son

Address Westminster, Maryland

19. 2/29 1940 (Date rec'd by registrar) G. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1940, at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 28 1940, to Feb 28 1940, and that I last saw her ~~alive~~ dead on Feb 28 1940.

Immediate cause of death Premature -6 mo.

Due to Premature Labor

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other

Address Westminster Md. Date signed Feb 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01737

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 yrs 7 mos

Stay in this community (yrs., or mos., or days): 2 yrs 7 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Caroline

City or town: Federalsburg. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: David B. McCrea

3. (b) Social Security Number: 714-01-8546-Poss

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1874

8. AGE:

Years	Months	Days	If less than one day
65	Unk	Unk	hrs. min.

9. Birthplace: Federalsburg, Md
(Town, county, and state)

10. Usual occupation: Printer

11. Industry or business

FATHER
12. Name: William T. McCrea
13. Birthplace: Md.

MOTHER
14. Maiden name: Martha Pennewell
15. Birthplace: Md.

16. Informant: Hospital Records

Address: Sykesville Md.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Mar. 2, 1940
(month) (day) (year)

Cemetery or crematory: Federalsburg

Location: Federalsburg Md.

18. Funeral director: J. Jerome Frampton

Address: Federalsburg Md.

19. 2-29-40 19 C Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 28 1940, at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 16 1937, to Feb 28 1940, and that I last saw him alive on Feb 28 1940.

Immediate cause of death: Pulmonary Tuberculosis

Due to

Due to

Other conditions: Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: Jan 29 1936 years

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Max Hayman
M. D. or other

Address: Springfield State Hosp. Date signed: 2/29/40

EIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (102)

CERTIFICATE OF DEATH

01738

Reg. Dist. No. 83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Rural m. Morgan
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 56 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural m. Morgan Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. R.D. Westminster, Md.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR No.

3. (a) FULL NAME Della B. ~~Mercer~~ Mercer

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1875

8. AGE: Years	Months	Days	If less than one day
64	7	0	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Edward Mercer
13. Birthplace Maryland

MOTHER
14. Maiden name Emily Mercer
15. Birthplace Maryland

16. Informant Eunice Gaither
Address R.D. # Sykesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 7, 1940 (month) (day) (year)

Cemetery or crematory Morgan Chapel
Location m. Woodbine, Carroll Co. Md.

18. Funeral director C. M. Waltz
Address Winfield, Md

19. Feb 6 1940 (Date rec'd by registrar) Edna M. Hewitt Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1940, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31, 1940, to Feb 5, 1940, and that I last saw h-m alive on Feb 4, 1940.

Immediate cause of death	DURATION
Pulmonary Oedema	1 da
Due to Lobar Pneumonia	4 da
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Stanley Grabill M. D. or other
Address Mt. Airy, Md Date signed 2/5/40

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MAR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01739

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll.

City or town: Rural nr. Morgan
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 88 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural nr. Morgan, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.D. Woodbine, Md
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No.

3. (a) FULL NAME: Serena H. Mercer

3. (b) Social Security Number: No.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single.

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 22, 1851

8. AGE:

Years	Months	Days	If less than one day
88	1	12	hrs. min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Augustus Mercer

13. Birthplace: Maryland.

MOTHER — 14. Maiden name: Amanda Beasman

15. Birthplace: Maryland

16. Informant: Miss Pearl Mercer

Address: Liston, Md

17. (Burial, cremation, or removal. Which?) Burial — Date thereof: Feb. 7, 1940 (month) (day) (year)

Cemetery or crematory: Morgan Chapel

Location: nr Woodbine, Md

18. Funeral director: C.M. Waltz

Address: Winfield, Md

19. (Date rec'd by registrar) Feb 6 1940 — Elva M. Hewitt, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 4, 1940, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1937 to Feb 4 1940, and that I last saw her alive on Feb. 3 1940.

Immediate cause of death	DURATION
Chr. Uremia	6 mo
Due to Chr Interstitial Nephritis	?
Due to Chr. Myocarditis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: No operation

Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Grabill, M. D. or other

Address: Mt Airy Md Date signed 2/15/40

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MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01740

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 15 yrs. 6 mo. 19 days.

Stay in this community (yrs., or mos., or days) Life.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Emmittsburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Unknown

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John S. Miller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1902

8. AGE:

Years	Months	Days	If less than one day
38		11	hrs. min.

9. Birthplace Emmittsburg, Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John Miller

13. Birthplace Maryland

MOTHER 14. Maiden name Sarah Treasler

15. Birthplace Maryland

16. Informant Hospital Records

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 1 1940 (month) (day) (year)

Cemetery or crematory Springfield Hosp. Cemetery

Location Sykesville Md.

18. Funeral director Harry Weer

Address Sykesville Md.

19. 2-29-40 19 (Date rec'd by registrar) Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1940, at 2:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 12 1939, to February 28 1940, and that I last saw him alive on February 28 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 12 1939
Due to	
Due to	
Other conditions Epilepsy	More than 15 years

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D. M. D. or other

Address Sykesville, Md. Date signed Feb. 28 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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MAR 4 1940
BUREAU V. S.

01741

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 4 years

Stay in this community (yrs., or mos., or days): 4 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Unk Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unk
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Airanna Moore

3. (b) Social Security Number:

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edgar Moore

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE: Years: 60 Months: Unk Days: Unk If less than one day ____ hrs. ____ min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Unk
13. Birthplace: Unk

MOTHER
14. Maiden name: Unk
15. Birthplace: Unk

16. Informant: Hospital Records

Address: Sykesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/2/40 (month) (day) (year)

Cemetery or crematory: Doubs Cemetery

Location: Frederick, Md

18. Funeral director: Harry E. Carty Co

Address: Frederick, Md.

19. Feb. 29 1940 (Date rec'd by registrar) O. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 29 1940, at 6 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 13 1936, to Feb 29 1940, and that I last saw her alive on Feb 29 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 years
Due to	
Due to	
Other conditions: Schizophrenia (Include pregnancy within 3 months of death)	28 years

Major findings:

Of operations:

Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Max Hayman M. D. or other

Address: Springfield State Hosp. Date signed: 2/29/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-P)

01742

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Rural Rt. Bird Hill
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 1 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Rt. Bird Hill Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. R.D. Westminster, Md.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR No.

3. (a) FULL NAME John Roger Muller

3. (b) Social Security Number No.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1940

8. AGE: Years — Months 1 — Days 2 — If less than one day — hrs. — min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Wm. Martin Muller
13. Birthplace Maryland.

MOTHER
14. Maiden name Naomi Staut.
15. Birthplace Maryland.

16. Informant Mrs. Martin Muller
Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 5, 1940 (month) (day) (year)
Cemetery or crematory Salem
Location Salem, Carroll Co., Md.

18. Funeral director C.M. Waltz
Address Union Mills, Md.

19. 2/4 (Date rec'd by registrar) 1940 H. Clay Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1940, at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1940 to Feb 3 1940, and that I last saw him alive on Feb 2 1940.

Immediate cause of death	DURATION
Malformation of heart (congenital)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Jennelle M. D. or other
Address Westminster Md. Date signed

RECEIVED
MAR 5 1940
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

01743

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll.
City or town Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days) 3 mos., 13 days.
Stay in this community (yrs., or mos., or days) Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Carroll.
City or town Westminster (rural) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR No record.

3. (a) FULL NAME George Myers.

3. (b) Social Security Number Unk.

4. Sex Male.

5. Color or race White.

6. (a) Single, married, widowed, or divorced Widowed.

6 (b) Name of ~~husband or~~ wife Sarah Wisner.

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Unknown.

8. AGE: Years 79(?) | Months Unk. | Days Unk. | If less than one day ____ hrs. ____ min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual occupation Farmer.

11. Industry or business

FATHER
12. Name John Myers.
13. Birthplace Unknown.

MOTHER
14. Maiden name ? Jair.
15. Birthplace Unknown.

16. Informant Springfield State Hospital.
Address Sykesville, Md.

17. Burial. Date thereof Feb. 19-1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Bartholomews Cemetery
Location York Rd.

18. Funeral director E. W. Little & Sons
Address Littlestown, Pa.

19. 2-15-40 19 ____ Harry Rees
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1940, at 5.55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 2, 1939, to Feb. 15, 1940, and that I last saw him alive on Feb. 15, 1940.

	DURATION
Immediate cause of death Cerebral Arteriosclerosis prior to 11-2-39.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE Harry F. Baer, M. D.
M. D. or other
Address Sykesville, Md. Date signed 2-15-40.

RECEIVED
MAR 4 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(940)

01744

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Rural near Taneytown
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 60 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Margaret E. Myers

3. (b) Social Security Number 213-03-1243

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife W. C. N. Myers

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1877

8. AGE: Years 62 Months 9 Days 16 If less than one day hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business operator in sewing factory

FATHER
12. Name Silas O. Shoemaker
13. Birthplace Md

MOTHER
14. Maiden name Mary J. Ridinger
15. Birthplace Md

16. Informant W. C. N. Myers

Address Taneytown, Md.

17. Burial Date thereof Feb 7, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Reformed

Location Taneytown, Md.

18. Funeral director C. D. Fuss & Son

Address Taneytown, Md.

19. Feb 6, 1940 Ethel M Mehring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4th 1940, at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 26th 1940, to Feb 4th 1940, and that I last saw her alive on Jan 30th 1940.

Immediate cause of death Angina Pectoris

DURATION 10 days

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. McBenner MD
M. D. or other

Address Feb. 6th 1940 Taneytown Md

RECEIVED
MAR 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (97)

01745

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 41 Webster Street
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 41 Webster Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME: Henry Nagel
3. (b) Social Security Number: None

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: Jennie Stultz
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) 11 – 11 – 1854
8. AGE: Years 85 | Months 2 | Days 29 | If less than one day ____ hrs. ____ min.
9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual occupation Cabinet maker
11. Industry or business
FATHER
12. Name Phillip Nagel
13. Birthplace Germany
MOTHER
14. Maiden name Elizabeth George
15. Birthplace Germany
16. Informant Mrs John W. Little
Address 41 Webster Street, Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 13 1940 (month) (day) (year)
Cemetery or crematory Deerpark Cemetery
Location Smallwood Carroll Co. Md.
18. Funeral director H Bankard & Son
Address Westminster, Maryland
19. 2/12 1940 (Date rec'd by registrar) F. Anderson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10th 1940, at 5 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Feb. 1st 1930, to Feb. 10th 1940, and that I last saw him alive on Feb. 11th 1940.

Immediate cause of death	DURATION
Senility	10 yrs.
Due to arteriosclerosis	15 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. L. Billingsley M. D. or other
Address Westminster, Md. Date signed 2/12/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (46) ✓ Reg. Dist. No. 80

CERTIFICATE OF DEATH

01746

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town New Windsor, Rural (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Carroll

(c) City or town New Windsor Rural (If outside city or town limits, write RURAL and give town)

(d) Street No. Near Marston (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Fannie Susan Maill

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct. 25 - 1861

8. AGE: Years 78 Months 4 Days 4 If less than one day ____ hr. ____ min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business At Home

FATHER

12. Name Wm. W. Maill

13. Birthplace Carroll Co Md.

MOTHER

14. Maiden Name Ann Baile

15. Birthplace Carroll Co. Md.

16 (a) Informant Mrs. Ed. M. Byers

(b) Address New Windsor, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 2 - 1940 (month) (day) (year)

(c) Cemetery or crematory Bethel Cem.

Location Near New Windsor Md.

18 (a) Funeral director U. W. Hartzler & Sons

(b) Address New Windsor Md.

19 (a) Tue 29 (Date rec'd by registrar) (b) Earl S. Bridel Registrar

MEDICAL CERTIFICATION

20. Date of death Feb. 29 1940, at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1940, to Feb. 29 1940, and that I last saw him alive on Feb. 27, 1940.

Immediate cause of death Cancer of stomach

Duration 2 or 3 years

Due to

Due to

Other conditions Extreme Emaciation

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. Reese Wilkens M. D. or other

Address Westminster Date signed Feb. 29 1940

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-D)

CERTIFICATE OF DEATH

01747

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Reisterstown. Rural. Near
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Reisterstown Rural Near Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Maggie Nese

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	maried

6 (b) Name of husband ~~or wife~~ Jacob Nese

6(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov. 7 - 1856

8. AGE:

Years	Months	Days	If less than one day
53	3	8	hrs. min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Albert Trump

13. Birthplace Maryland

MOTHER 14. Maiden name

15. Birthplace

16. Informant Jacob Nese

Address Reisterstown R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 17-1940 (month) (day) (year)

Cemetery or crematory Meadow ~~Branch~~ Cemetery

Location Mt. Westminster, Maryland

18. Funeral director H Bankard & Son

Address Westminster, Maryland

19. 2/16 1940 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1940, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-29 1939, to Feb 15 1940, and that I last saw her alive on Feb 8 1940

Immediate cause of death Cardiac Decompensation 4 yrs. — DURATION

Due to Hypertensive C-V. Disease ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) None (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. D. Caples, M.D.
M. D. or other

Address Reisterstown Date signed 2-16-'40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01748

Reg. Dist. No. 79

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 yr., 5 mos., 14 days

Stay in this community (yrs., or mos., or days): 1 yr., 5 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 4024 Stafford St (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Katherine O'Halloran

3. (b) Social Security Number: 066-07-1101-Pass

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: unknown

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: 60 Months: Days: If less than one day: hrs. min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: Hospital Attendant

11. Industry or business:

FATHER: 12. Name: James McDonald

13. Birthplace: Ireland

MOTHER: 14. Maiden name: Delia Macanroe

15. Birthplace: Ireland

16. Informant: Joseph O'Halloran

Address: 4024 Stafford St, Baltimore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-19-40 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: Old Frederick Rd

18. Funeral director: John J. Cowan & Son

Address: 901 Hollins St

19. 2-15-40 (Date rec'd by registrar) 19 C Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14 1940, at 9:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sep. 1 1938, to Feb. 14 1940, and that I last saw her alive on Feb. 14 1940.

Immediate cause of death	DURATION
Bronchopneumonia	3 days
Erysipelas	8 days
Due to	
Due to	
Other conditions: Hypertensive cardiovascular disease with cerebral hemorrhage (Include pregnancy within 3 months of death)	5 yrs.

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed: 2-15-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01749

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 Month, 3 days
Stay in this community (yrs., or mos., or days): (above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Oxen Hill Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: James Woodrow Proctor

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife: ---
6(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): March 13, 1936

8. AGE: Years	Months	Days	If less than one day
3	10	27	hrs. min.

9. Birthplace: Newberg, Cahrles Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: ---

FATHER
12. Name: William A. Proctor
13. Birthplace: Newberg, Charles County

MOTHER
14. Maiden name: Mary Harley
15. Birthplace: Newberg, Charles County

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 2 13 40 (month) (day) (year)
Cemetery or crematory: St. Lukes
Location: Sykesville
18. Funeral director: Warr & Son Inc.
Address: Sykesville, Md.

19. 2/9/40 (Date rec'd by registrar) 19 Albert R. Swinehart Dep Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 8 1940, at 9:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6, 1940 to Feb. 8 1940, and that I last saw him alive on Feb. 8 1940

Immediate cause of death	DURATION
Miliary tuberculosis	2 mos,
Due to tuberculosis of hip	2 mos.
Due to	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: Miliary Tuberculosis

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 2/8/40

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

01750

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural - near Westminster (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) 3 Carroll Co Home

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Carroll

City or town Rural - near Westminster (If outside city or town limits, write RURAL NEAR and give town)

Street No. — (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Geo W. Reese

3. (b) Social Security Number none

4. Sex Ml

5. Color or race Wh

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife X

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb - 1868

8. AGE: Years 72 Months — Days — If less than one day ____ hrs. ____ min.

9. Birthplace Balto Co. Md. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Ezra Edw. Reese

13. Birthplace Garrison, Md.

MOTHER 14. Maiden name Mary A. Reese

15. Birthplace Balto. Md.

16. Informant Geo. Bankert.

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 (month) 20 (day) 40 (year)

Cemetery or crematory Carroll County home Cem.

Location near Westminster Md

18. Funeral director J. E. Myers Jr.

Address Westminster, Md.

19. 2/20 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19-40 19__, at 7.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-27- 1939, to 2-19- 1940, and that I last saw him alive on 2-18 1940.

Immediate cause of death Chronic valvular heart disease — DURATION many yrs

Due to Causes unknown

Due to " "

Other conditions Pulmonary edema — 2 days

(Include pregnancy within 3 months of death)

Major findings:

Of operations no operation

Of autopsy no autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) no

Means of injury Injured at work?

23. SIGNATURE W. C. Stone MD M. D. or other

Address Westminster Date signed 2-19-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

01751

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 29 yrs 10.mos30das.

Stay in this community (yrs., or mos., or days): same

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 101 S. Monastery Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John J. Reilly

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1869

8. AGE: Years: 70 Months: ? Days: It less than one day: hrs. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ?

FATHER
12. Name: John Reilly
13. Birthplace: ?

MOTHER
14. Maiden name: Ann Connor
15. Birthplace: ?

16. Informant: Hospital Record

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 8 1940 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Baltimore Md.

18. Funeral director: William Cook

Address: 1217 St. Paul St

19. Feb 5 1940 (Date rec'd by registrar) C Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5 1940, at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1, 1938 19 , to Feb. 5 1940, and that I last saw him alive on Feb. 5, 1940.

Immediate cause of death: Cerebral hemorrhage — DURATION: immediate

Due to: Cerebral arteriosclerosis — 2 yrs.

Due to:

Other conditions: Dementia Praecox, Paranoid type — 40 yr
(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

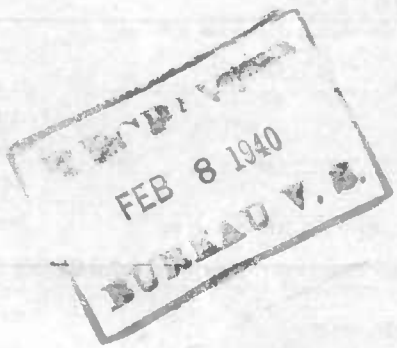
23. SIGNATURE: Samuel Barkoff M.D. M. D. or other

Address: Sykesville, Md Date signed: 2/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


FEB 8 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

01752

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 4 days -

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland - County Allegany -

City or town Cumberland, Md - Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. unknown
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Daniel Shipley

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Cross -

6(c) If alive, give age unk - years

7. Birth date of deceased (mo., day, yr.) August 3, 1877 -

8. AGE: Years 62 | Months 6 | Days 20 - | If less than one day ____ hrs. ____ min.

9. Birthplace Pennsylvania -
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Dawson Shipley
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Martha Schneider
15. Birthplace Pennsylvania

16. Informant Hospital Records

Address Sykesville, Md -

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-26-40 (month) (day) (year)

Cemetery or crematory

Location Cumberland Md

18. Funeral director Louis Stein Clm

Address Cumberland Md

19 2-23-40 (Date rec'd by registrar) 19 C Harry Weco Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1940, at 9 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 1940, to February 23 1940, and that I last saw h in alive on February 22 1940 -

Immediate cause of death	DURATION
Hanging - Suicide	2-23-40
Due to Mental Illness	2 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of Feb. 23/40

Where did injury occur? Sykesville (City or town) Carroll (County) Md. (State)

Injured at home, farm, industry, public place (where?) Hospital -

Means of injury Hanging - Injured at work? no

23. SIGNATURE Jas. T. Marsh Deputy Medical Examiner M. D. or other

Address New Windsor Md Date signed 2/23/40

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-c)

01753

CERTIFICATE OF DEATH

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Hampstead - Rural

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Snydersburg

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Hampstead Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Snydersburg

(If rural, give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Roy Clarence Simmons

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Greta V. Simmons

6(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) March 25 - 1891

8. AGE: Years	Months	Days	If less than one day
48	10	14	____ hrs. ____ min.

9. Birthplace Sand No Westminster Carroll Co. Md

(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER 12. Name John Simmons

13. Birthplace Maryland

MOTHER 14. Maiden name Alice Spencer

15. Birthplace Maryland

16. Informant Mrs. Roy C. Simmons

Address Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 10/40 (month) (day) (year)

Cemetery or crematory Zion's Lutheran

Location near Westminster Md

18. Funeral director Edw C Tipton

Address Hampstead Md

19. 2-9 (Date rec'd by registrar) 1940. John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1940 after 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death	DURATION
Bullet Wound of Head	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Suicide Date of Feb 8. 40

Where did injury occur? Snydersburg (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury 22 rifle Injured at work? No.

23. SIGNATURE J. T. Hood Deputy Medical Examiner

M. D. or other

Address New Windsor Md Date signed 2/8/40

FEB 19 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

1754

Reg. Dist. No. 712

1. PLACE OF DEATH:
County Carroll
City or town Sykesville Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days) 2 mos 20 days
Stay in this community (yrs., or mos., or days) 2 mos 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore City
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1608 E. Lonnale St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Rudolphine Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Unknown
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1863

8. AGE: Years	Months	Days	If less than one day
76	1	26	____ hrs. ____ min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation None
11. Industry or business None
FATHER 12. Name Ernest Baker
13. Birthplace Germany
MOTHER 14. Maiden name ? Sachdad
15. Birthplace Germany
16. Informant Hospital Records
Address Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 13-40 (month) (day) (year)
Cemetery or crematory Louden Park
Location Balto Md
18. Funeral director Geoage Weber & Son
Address 2563 Edmondson Ave.
19. Feb 10 1940 (Date rec'd by registrar) C Harry Weber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1940, at 5:30 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 1939 to Feb 10 1940
and that I last saw h[illegible] alive on Feb 10 1940

Immediate cause of death: Cerebral Thrombosis — DURATION: Instantaneous
Due to: Cerebral Arterio - Sclerosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy: as above

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Max Hayman M.D. M. D. or other
Address Springfield State Hosp. Date signed 2/10/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
FEB 15 1940
BUREAU V. 1

STATE OF MARYLAND—CERTIFICATE OF DEATH

01755

131-a

1. PLACE OF DEATH

County Carroll Registration Dist. No. 81.

Village or City Union Bridge No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residance in city or town where death occurred 2 yrs. mos. ds. How long in U.S. if of foraign birth? yrs. mos. ds.

2. FULL NAME Mary Virginia Sinsemy, Sensemy

(a) Residence: No. Union Bridge St., Ward. Md.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: John H. Sinsemy, ensemy

6. DATE OF BIRTH (month, day, and year): June 5, 1853

7. AGE: Years 86 | Months 8 | Days 23, | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Home

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Own Home

10. Date deceased last worked at this occupation (month and year): 1914

11. Total time (years) spent in this occupation: 8 yrs.

12. BIRTHPLACE (city or town) (State or country): Maryland

FATHER

13. NAME: Richard Parrish

14. BIRTHPLACE (city or town) (State or country): Maryland

MOTHER

15. MAIDEN NAME: Sarah Sinsemy

16. BIRTHPLACE (city or town) (State or country): Maryland

17. INFORMANT (Address): Debbie Hollenbrook, Union Bridge

18. BURIAL, CREMATION, OR REMOVAL

Place Mt View Cem. Date Mar. 2, 1940

19. UNDERTAKER (Address): D. D. Hartzler & Sons, Union Bridge, Md.

20. FILED Mar. 1, 1940 P. Eichman, Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH: February (Month) 29 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1940, Feb. 29, 1940

I last saw her alive on Feb. 28, 1940 death is said to have occurred on the date stated above, at 5 a. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Arteriosclerosis & Chronic Nephritis

Date of onset

Other Contributory Causes of Importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accidant, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) John H. Musselman M. D.

(Address) Johnsville, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

01756

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Carroll Home of the Aged

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 9 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. W. Main (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Alice Virginia Spencer

3. (b) Social Security Number none

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Paul C. Spencer

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15 - 1865

8. AGE: Years 75 Months 1 Days 4 If less than one day hrs. min.

9. Birthplace Westminster, Carroll, Maryland (Town, county, and state)

10. Usual occupation nurse

11. Industry or business Thomas

FATHER 12. Name ~~[illegible]~~ Gist

13. Birthplace Maryland

MOTHER 14. Maiden name ~~[illegible]~~ ~~Crouse~~ Mary Sheets

15. Birthplace Maryland

16. Informant Mrs Millie E. Little

Address Carroll Home, Westminster, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Feb. 22 - 1940 (month) (day) (year)

Cemetery or crematory Greenmount

Location Baltimore Md.

18. Funeral director H Bankard & Son

Address Westminster, Maryland

19. Feb 21 1940 (Date rec'd by registrar) C R Fogle Registrar Dep Local

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20th 1940, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 9th 1940, to Feb 20th 1940, and that I last saw her alive on Feb. 19th 1940.

Immediate cause of death Acute Coronary Thrombosis - 10 days

Due to

Due to

Other conditions Chr. Interstitial Nephritis

(Include pregnancy within 3 months of death)

Major findings: None

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Shuster Bove M. D. or other

Address Westminster Md. Date signed 2/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

01757

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town near Manchester
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or Inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 78-0-10

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town near Manchester Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles H. H. Stewart

3. (b) Social Security Number None

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Alice A Stewart
6(c) If alive, give age: Deceased years
7. Birth date of deceased (mo., day, yr.): Feb. 14. 1862
8. AGE: Years 78 Months 0 Days 10 If less than one day hrs. min.
9. Birthplace: Maryland (City, county, and state)
10. Usual occupation: Cigar maker
11. Industry or business
FATHER 12. Name: George Stewart
13. Birthplace: Ireland
MOTHER 14. Maiden name: Susan Rupp
15. Birthplace: Maryland
16. Informant: Geo. H. H. Stewart
Address: Manchester Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-27-40 (month) (day) (year)
Cemetery or crematory: cemetery
Location: Manchester, Md
18. Funeral director: Jacob Winks Sons
Address: Manchester Md
19. Feb. 27 1940 (Date rec'd by registrar) M. H. S. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 24 1940, at 1A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940, to Feb 24 1940, and that I last saw him alive on Feb 12, 1940.

Immediate cause of death: Coronary Sclerosis — DURATION: 8 mos
Due to: Arteriosclerosis — 2
Due to: — 1
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE W R S Denner M. D. or other
Address Manchester Md Date signed 2/26/40

RECEIVED
MAR 18 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-a

CERTIFICATE OF DEATH

01758

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Edna May Storms

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): January 28, 1892

8. AGE: Years	Months	Days	If less than one day
48	0	13	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: James M. Storms
13. Birthplace: Maryland

MOTHER
14. Maiden name: Catherine Baker
15. Birthplace: Maryland

16. Informant: James M. Storms
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Jan. 12, 1940 (month) (day) (year)

Cemetery or crematory: Leister's Cemetery

Location: near Westminster, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 2/11/40 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10th 1940, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 30th 1940, to Feb 10th 1940, and that I last saw h-- alive on Feb. 9th 1940.

Immediate cause of death: Vascular Disease of Brain (Hemorrhage of the cerebellum) 8

DURATION: Unknown

Due to: unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. L. Billingslea M. D. or other

Address Westminster, Md. Date signed 2/10/40

RECEIVED
MAR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01759

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 13 days
Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent Co.
City or town Kent Narrows Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR --

3. (a) FULL NAME: Clarence Strong

3. (b) Social Security Number: 218-10-0414 - Ross

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife --
6(c) If alive, give age -- years
7. Birth date of deceased (mo., day, yr.) Nov. 18, 1884

8. AGE: Years 55 | Months 2 | Days 14 | If less than one day ___ hrs. ___ min.

9. Birthplace Hampton, Virginia (Town, county, and state)
10. Usual occupation Oyster Shucker
11. Industry or business --

FATHER
12. Name Henry Strong
13. Birthplace Unknown

MOTHER
14. Maiden name Myra Strong
15. Birthplace Hampton, Va.

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-4-40 (month) (day) (year)
Cemetery or crematory St. Lukes Cemetery
Location Sykesville Md
18. Funeral director C Harry Weir
Address Sykesville Md.

19. 2/1/40 (Date rec'd by registrar) 19 Albert R Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1940 19 12;20 A.M. at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 19, 1940 19 to Feb. 1, 1940 19
and that I last saw him alive on Feb. 1, 1940 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1939
Due to ---
Due to ---
Other conditions ---
(Include pregnancy within 3 months of death)
Major findings:
Of operations ---
Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Maryland Date signed 2/1/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

01760

Reg. Dist. No. 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Mt. Airy (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Rural
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 25 year

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural Mt. Airy Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Alexander Thompson

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6 (b) Name of husband or wife unknown

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1858

8. AGE: Years	Months	Days	If less than one day
81	8	22	hrs. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. William Darrall

Address Mt. Airy

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 4 1940 (month) (day) (year)

Cemetery or crematory Damascus

Location Damascus Montgomery Co.

18. Funeral director H. M. Snyder

Address Mt. Airy

19. Feb. 3 1940 (Date rec'd by registrar) Thos D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2/40 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/1/40 19 to 2/2/40 19 , and that I last saw h alive on 2/1/40 19 .

Immediate cause of death	DURATION
Cerebral apoplexy	1 day
Due to Hypertension — Chr.	7
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Stanley Grabill M. D. or other
Address Mt. Airy, Md. Date signed 2/2/40

RECEIVED
MAR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

01761

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 51 Bishop St.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 5 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Westminster R.D. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 51 Bishop
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John F. Utermohlen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

B (b) Name of husband or wife: Mary E. Wagner Utermohlen
B(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 23, 1858

8. AGE: Years	Months	Days	If less than one day
81	4	29	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Cigarmaker
11. Industry or business

FATHER
12. Name: John Utermohlen
13. Birthplace: Germany

MOTHER
14. Maiden name: Louisa Sittig
15. Birthplace: Germany

16. Informant: Ernest Steluding
Address: 51 Bishop St. Westminster, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 24, 1940 (month) (day) (year)
Cemetery or crematory: Pleasant Valley
Location: Pleasant Valley
18. Funeral director: C. O. Fuss & Son
Address: Taneytown, Md

19. Feb 23 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 22 1940, at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 17 1940, to Feb 22 1940, and that I last saw him alive on Feb 22 1940.

Immediate cause of death	DURATION
Cardio vascular Renal disease	
Myocardial degeneration	
Due to Senility & Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. Edward Speaker M. D. or other
Address: Westminster Date signed: Feb. 23

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MAR 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01762

1. PLACE OF DEATH (51-E) ✓

County Carroll. Registration Dist. No. 82

Village or City Harrisville, Md. No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Geo. W. Wagner If U. S. Veteran, specify WAR No.

(a) Residence: No. R.D. #1. Taney, Md. St., Ward.
(Usual place of abode) If nonresident give city or town and State

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married.

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Effie C. Wagner 78yr.

6. DATE OF BIRTH (month, day, end year) May 16, 1862

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	9	13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farmer.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Carroll Co.
(State or country) Md.

FATHER

13. NAME William Wagner

14. BIRTHPLACE (city or town)
(State or country) Md.

MOTHER

15. MAIDEN NAME Annie Powell

16. BIRTHPLACE (city or town)
(State or country) Md.

17. INFORMANT Mrs. Effie C. Wagner
(Address) R.D. #1. Taney, Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Evergreen Cem'ty Date March 3, 1940

19. UNDERTAKER C.M. Waltz
(Address) Winfield Md

20. FILED Mar 2, 1940 Thos D Snyder
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb. (Month) 29 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Feb 28, 1940, to Feb 29, 1940

I last saw h~~im~~ alive on Feb 27, 1940; death is said to have occurred on the date stated above, at 5:15 p.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Carcenoma of Prostate	?
Other Contributory Causes of importance: Metastases, including liver	?

Name of operation None Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) J. Stanley Grabill M. D.

(Address) Taneytown, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

RECEIVED
APR 6 1940
BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01763

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 year 6 Mos. 20 days
Stay in this community (yrs., or mos., or days): (Same as above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1402 Bethel St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary King Welthington

3. (b) Social Security Number: --

4. Sex: Female
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Joseph Welthington
6(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb. 7, 1897

8. AGE: Years: 42 Months: 11 Days: 26 If less than one day: hrs. min.

8. Birthplace: Wilson, N. Carolina (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: --

FATHER
12. Name: Henry King
13. Birthplace: Park County, N. Carolina

MOTHER
14. Maiden name: Nancy Brown
15. Birthplace: North Carolina

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal, Which) Date thereof: Feb. 7 1940 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cemetery
Location: A A Co. Md
18. Funeral director: Robert E. Williams
Address: 1515 McElderry St
19. 2/3/40 (Date rec'd by registrar) 19 Albert R. Swarthouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 3, 1940 19 9:00 A.M., at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13, 1938 19, to Feb. 3, 1940 19, and that I last saw her alive on Feb. 3, 1940 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: June 1938
Due to: --
Due to: ---
Other conditions: ---
(Include pregnancy within 3 months of death)
Major findings:
Of operations: ---
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? (City or town) -- (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: -- Injured at work? ---

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 2/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

FEB 8 1940
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01764

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll County

City or town: Sykesville, Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 6 yr. 10 mos. 17 days

Stay in this community (yrs., or mos., or days) 6 yr. 10 mos. 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 909 Light Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Harry Wessels

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Marie French

6(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): October 27, 1891

8. AGE: Years	Months	Days	If less than one day
48	5	20	____ hrs. ____ min.

9. Birthplace: Accomac, Virginia (Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business: ?

FATHER 12. Name: Judson Wessels

13. Birthplace: Virginia

MOTHER 14. Maiden name: Ella Taylor

15. Birthplace: Virginia

16. Informant: Hospital Record.

Address: Sykesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-19-40 (month) (day) (year)

Cemetery or crematory: London Park Cemetery

Location: Frederick Rd.

18. Funeral director: Wm. M. Maricle

Address: Light & Montgomery Sts.

19. 2-19-40 (Date rec'd by registrar) 19__ Harry Green Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 17, 1940, at 6:15 am M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1938, to February 17 1940, and that I last saw him alive on Feb. 16 1940.

Immediate cause of death	DURATION
Chronic myocarditis with pulmonary infarction and oedema	?
Due to ?	
Due to	
Other conditions: General paralysis of the insane (Include pregnancy within 3 months of death)	1932

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Samuel Barkoff M.D. M. D. or other

Address: Sykesville Md. Date signed: 2/17/40

FEB 21 1940
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01765

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 19 days

Stay in this community (yrs., or mos., or days): (Same as above)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1608 Harlem Ave. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Noami Williams

3. (b) Social Security Number: 11-08-39

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

B (b) Name of husband or wife: Moses Williams

6(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): May 31, 1914

8. AGE: Years	Months	Days	If less than one day
25	8	26	____ hrs. ____ min.

9. Birthplace: Ruckersville, Va. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER

12. Name: Steve Redman

13. Birthplace: Ruckersville, Va.

MOTHER

14. Maiden name: Minnie Armstead

15. Birthplace: Westpoint, Va.

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb. 28, 1940 (month) (day) (year)

Cemetery or crematory: Ruckersville

Location: Ruckersville, Va.

18. Funeral director: Easton Sons

Address: Elkridge city md.

19. a/26/40 (Date rec'd by registrar) Albert R. Swankhone Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 26, 1940 19____, at 6.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 7, 1940 19____, to Feb. 26, 1940 19____ and that I last saw her alive on Feb. 26, 1940 19____.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1939
Due to --	
Due to --	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings:

Of operations ---

Of autopsy: No Autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? -

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 2/26/40

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01766

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 2 Mos. 13 days

Stay in this community (yrs., or mos., or days): (Same as Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 409 Morse St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Edward Wilson

3. (b) Social Security Number: 212-14-8108

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Louise Wilson

6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): Oct. 10, 1915

8. AGE: Years	Months	Days	If less than one day
24	4	4	____ hrs. ____ min.

9. Birthplace: Trio, S. C.
(Town, county, and state)

10. Usual occupation: Presser

11. Industry or business: Unknown

FATHER
12. Name: Edward Wilson
13. Birthplace: Unknown

MOTHER
14. Maiden name: Maggie Thompson
15. Birthplace: Unknown

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-17-40 (month) (day) (year)

Cemetery or crematory: Int. Calvary Cem.

Location: A. A. Co. Md.

18. Funeral director: Chas. F. Alexander

Address: 1200 W. Fayette St.

19. 2/14/40 (Date rec'd by registrar) 19 Albert R. Smackhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14, 1940 12:30 A.M. 19 ____, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1, 1939 19 ____, to Feb. 14, 1940 19 ____, and that I last saw h__ im alive on Feb. 14, 1940 19 ____.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of ____

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other

Address: Henryton, Md. Date signed 2/14/40

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01767

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 27 days
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 421 George St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Theodore Harden Wilson

3. (b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6(b) Name of husband or wife: --

6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): March 12, 1921

8. AGE:

Years	Months	Days	If less than one day
18	11	0	____ hrs. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: --

FATHER
12. Name: Harvey Blackwell
13. Birthplace: Scottsville, Va.

MOTHER
14. Maiden name: Mamie Wilson
15. Birthplace: Scottsville, Va.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-15-40 (month) (day) (year)
Cemetery or crematory: Scottsville Cemetery
Location: Scottsville Va

18. Funeral director: William J. Jackson
Address: 916 Penna ave

19. 2/12/40 (Date rec'd by registrar) Albert R. Swankham Deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12, 1940 19____, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 16, 1940 19____ to Feb. 12, 1940 19____, and that I last saw him alive on Feb. 12, 1940 19____.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Oct. 1939

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. (M. D. or other)
Address: Henryton, Md. Date signed: 2/12/40

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01768

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Carroll

City or town Rural near Taneytown (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 14 yr

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State County

City or town Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Isaac a. Wilt

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Geraldine Wilt

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1883

8. AGE: Years	Months	Days	If less than one day
56	8	14	hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name James a. Wilt

13. Birthplace Md

MOTHER 14. Maiden name Catherine Stokes

15. Birthplace Md.

16. Informant Geraldine Wilt

Address Westminster, Md R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 8, 1940 (month) (day) (year)

Cemetery or crematory Lutheran

Location Taneytown, Md

18. Funeral director C. O. Duss & Son

Address Taneytown, Md.

19. 2/6 1940 (Date rec'd by registrar) C. O. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1940, at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1939, to Feb. 5 1940, and that I last saw h[illegible] alive on Feb. 5 1940.

Immediate cause of death	DURATION
Chronic Nephritis with Edema	1 yr.
Due to	
Due to	
Other conditions Chronic Myocarditis	1 yr.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M.D.

M. D. or other

Address Taneytown Date signed 2/6/40

RECEIVED
MAR 5 1940
BUREAU V. S.